Hands in the Sky
Massage Therapy

HEALTH HISTORY FORM

PLEASE COMPLETE FORM IN FULL

Name: ______________________ Date of birth: ______________

Address: ______________________ City: ______________ Postal code: __________

Home Phone: __________ Cell: __________ Work: ______________

Email address: ______________________ Occupation: ______________________

Preferred contact: ______________________ Referred by: ______________________

How did you hear about us? ____

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future please let us know. All information gathered is confidential except as required by law. You will be asked to provide written authorization for release of any information.

☑ Please indicate conditions you are experiencing or have experienced.

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Heart disease
- ❑ Phlebitis
- ❑ Stroke / CVA
- ❑ Pacemaker or similar device
- ❑ Varicose veins

Respiratory
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking

Head/Neck
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss
- ❑ Headaches
- ❑ Type: ______________

Soft tissue/joint
- ❑ Neck
- ❑ Low back
- ❑ Mid back
- ❑ Upper back
- ❑ Shoulders
- ❑ Arms R / L
- ❑ Legs R / L
- ❑ Knees R / L
- ❑ Other: ______________

Infections
- ❑ Hepatitis
- ❑ TB
- ❑ HIV
- ❑ Plantar warts
- ❑ Other: ______________

Other Conditions
- ❑ Loss of sensation
- ❑ Diabetes
- ❑ Allergies
- ❑ Epilepsy
- ❑ Cancer
- ❑ Arthritis

Women
- ❑ Menstrual problems
- ❑ Menopausal
- ❑ Children: ______________
- ❑ Pregnant
- ❑ Due date: ______________

Skin
- ❑ Skin conditions
- ❑ Skin irritations
- ❑ Bruise easily

What is your general health status? ____

Current Medications______________________ Condition it treats______________________

Previous Surgery (date & nature) ____

Previous Injury (date & nature)______________________________(e.g. dislocation/fracture/car accident)

Other Medical Conditions (e.g. digestive disorders, gynecological problems)______________________

Of Special Note (presence of internal pins, wires, special equipment)______________________

Primary Care Physician (name & phone number)______________________________

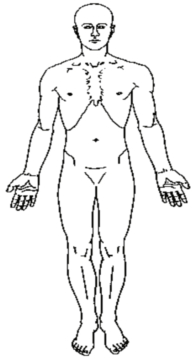
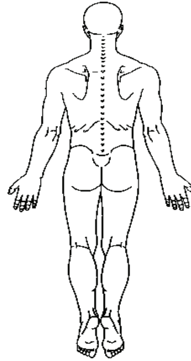
Other Healthcare (e.g. chiropractor, naturopath, physiotherapist)______________________

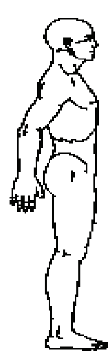
Have you received massage therapy before? ❑ Yes ❑ No If yes, date of last visit ______________

Do you exercise regularly (i.e. 3 times per week) ❑ Yes ❑ No If yes, what do you do ______________

What is the reason you are seeking Massage Therapy?______________________________

MAIN COMPLAINT



Location of the pain. Please use the diagrams above. Try to be as specific as you can.

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Cause of the pain ____

How long have you had the pain? ____

How frequent is the pain? (all day/night/only when you get up) ______________________________

How intense is the pain? (scale of 1 –10) ____

How would you describe the pain? (achy, throbbing, burning) __________________________

What makes the pain increase? ____

What makes the pain decrease? ____

What medications are you presently taking for the condition? (muscle relaxants, painkillers)__________________

Is there a history of this condition? ____

Have you received any other treatment for this condition? If yes, please describe and comment on its success____________

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What results do you desire from your treatment? ___________________________________

Informed Consent to Treatment

Massage Therapy involves the manipulation of the soft tissues of the body, skin, muscle, ligaments and connective tissues, using techniques to produce therapeutic results.

With Massage Therapy, the client disrobes to their comfort level, and lies on a table between two sheets. Only the areas of the body being directly treated are uncovered at one time. If at any time you are uncomfortable with the pressure or technique being used, you can tell the therapist (i.e. to decrease or increase pressure, irritating, etc). You can also stop the treatment at any time.

I have read the above and give consent for treatment. 24 hours notice is required for cancellation of an appointment to avoid charges.

Signature: ____________________________________ Date: ____________________

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